Inquiring into Multi-layered, Preventative Partnership Working

Community Capacity-Building for Health and Wellbeing Case Study

Co-produced by Aberdeenshire Community Planning Partnership and What Works Scotland

Case study

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This case study is an accompanying document to the collaborative research report *Inquiring into Multi-layered, Preventative Partnership Working.*

References within this case study to the "research report" are in respect of this.

Read and download the report on the What Works Scotland website at: whatworksscotland.ac.uk/publications/inquiring-into-multi-layered-preventative-partnership-working

Introduction

The shift towards the integration of health and social care services, most recently through the Public Bodies (Joint Working) (Scotland) Act 2014, and the arrival of Health and Social Care Partnerships and Integrated Joint Boards has brought an increasing focus on the role of communities, service users and carers in working with services to improve their health and wellbeing.

With an ageing population, stubborn health inequalities and (currently) constrained public service spending, the fear is that services will be overwhelmed by demand. A shift away from reactive or 'symptomatic' services, and towards preventative approaches that seek to reduce demand, is therefore a key element in the HSCP's strategic thinking – in particular as a focus on 'population health' (see 3.3 in the research report). The 2011 Christie Commission, in advocating for such preventative approaches to inequality, also puts emphasis on the importance of the local accountability of services, community-led solutions, local partnerships and the development of a 'virtuous circle' between public services, balanced economic development and community empowerment (see 2.2, 2.5 in the research report).

With such thinking in mind, Aberdeenshire HSCP and CPP have been working with What Works Scotland to explore various collaborative learning approaches across public and third/community sectors that can inform the HSCP's developing strategic approach to such community capacity-building (CCB) – and in the context of seeking to prevent health inequalities. This case study illustrates three such collaborative processes that seek to build (accumulate) understanding of good practice in CCB and integrate this learning with developing approaches and evidence on preventing inequality, namely:

- a participatory workshop to map current 'community approaches' and related CCB work across the CPP; and consider emerging issues and solutions;
- the use of an in-depth collaborative inquiry – to deepen understanding of 'good practice' and the policies and contexts that support good practice;
- on-going discussions drawing on local and national evidence sources to support the HSCP to develop a strategic and preventative approach to CCB.

This case study concludes with What Works Scotland commentary on the learning from this developing collaborative approach to prevention through CCB.

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1. Dialogue: a strategic approach to community capacity-building

In December 2016, Aberdeenshire HSCP and What Works Scotland facilitated a participatory workshop with partners from across the CPP including the third and community sector(s) and those working in strategic, operational, development and community-facing roles.[1] This had the broad aim of building shared understandings of partners and their community capacity-building (CCB) plans and capacities – in relation to health and wellbeing – so that longer-term shared agendas, strategies and activities can better emerge.

Providing the 'challenge' for the day: the HSCP's Strategic Plan 2016-19[2] recognizes that:

> *…there is already a strong network of partners working with and in communities. So... what should or can we collectively focus on? How can we optimise our shared capacity? Who is best placed and able to deliver what?*

The HSCP was therefore keen to explore further across its CPP partners the variety and extent of existing approaches to working with communities (community approaches); and related work by public sector and third/community sector bodies to develop the capacity of communities to support their own health and wellbeing. Alongside the HSCP's own consultative work, two other sources of evidence were highlighted before the workshop:

- Nationally: Joseph Rowntree Foundation's (Crisp et al., 2016) *Community-led approaches to reducing poverty in neighbourhoods: a review of evidence.*[3]
- Locally: *Community Links Worker Report* (see section 2) … with three of the workshop participants having direct experience of community and partnership working there.

A process for participation and dialogue: the workshop was designed as three phases:

- *scene-setting:* getting to know more about other participants and organisations; and understanding more about the HSCP's strategy and some relevant evidence.
- *initial mapping:* to use the experience in the room to understand more about co-production, community enterprise and community sector activity across the CPP.
- *shared learning:* considering opportunities and barriers to developing a strategic approach and in the process building understanding of the wider policy context.

Both the scene-setting and initial mapping work aimed to support the participants and the What Works Scotland researchers to engage in deepening discussions.

Some examples are in the following illustrations.

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[1] Including: Aberdeenshire ADP; Older People and Community Care Services; HSCP Locality Team; Local Community Planning; Community Health in Partnership Team (AVA); Friends of Insch Hospital and Community; Rural Partnerships; Community Learning and Development; and Public Health (NHS Grampian). Participants included those working in strategic management, operational management, development and community-facing roles and volunteer/activist roles…. some attending as staff pointed to their volunteer/activist roles too.

[2] https://www.aberdeenshire.gov.uk/media/16182/health-and-social-care-strategic-plan-march-2016-final.pdf

[3] https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/community-led-approaches-to-reducing-poverty-in-neighbourhoods.pdf

1.1 Initial mapping: community approaches and community capacity-building

Examples of voluntary action

Befriending Services e.g. Kincardine & Deeside Befriending Service

Recovery Cafes: peer-led in Banff, identified themselves. No staff attendance (ADP holds bank account

Braemar care initiative for local people, using local residents. Recognised needs of residents. Steering group from wider Aberdeenshire

Inspiring Insch – community café: open to anyone – run on donations: concerned to be inclusive as some young mums hadn't felt welcome at another activity

Peterhead Drummers Corner (monthly) – themes, like super Saturday; also run a café and language groups

Huntly runs a street fair for traders – a public space

Community Learning and Development: volunteers directly deliver ESOL (English for Speakers of Other Languages) Core Skills Training to learners (after training)

Volunteer-run Local Day Services for older people in Aboyne: funding from Aberdeenshire Council

Development Trusts and Rural Area Partnerships (building support capacity)

Response to the floods (e.g. Aboyne, Ballater) – community coming together in crisis and helping e.g. setting up a foodbank; young people filling sandbags. And a legacy being generated, for instance, a form of time-banking

Examples of community enterprise

Networks of Wellbeing in Huntly – mental health charity that refurbishes old bicycles, has worked with Syrian 'New Scot' refugees

SensationAll for young people with multiple support needs

Bellwade Farm (Learning disabilities support)

Community Development Trusts:

- Laurencekirk
- Huntly – has a farm, turbine (grid access an issue)
- Boyndie Trust – Café, Community Transport
- Stonehaven Towns Partnership

Meldrum Community Café

Maggie Law Maritime Museum

Community Halls at Mintlaw, Insch, New Macchar, Blackburn

Fly-Cup in Inverurie – catering social enterprise that employs adults with learning disablities

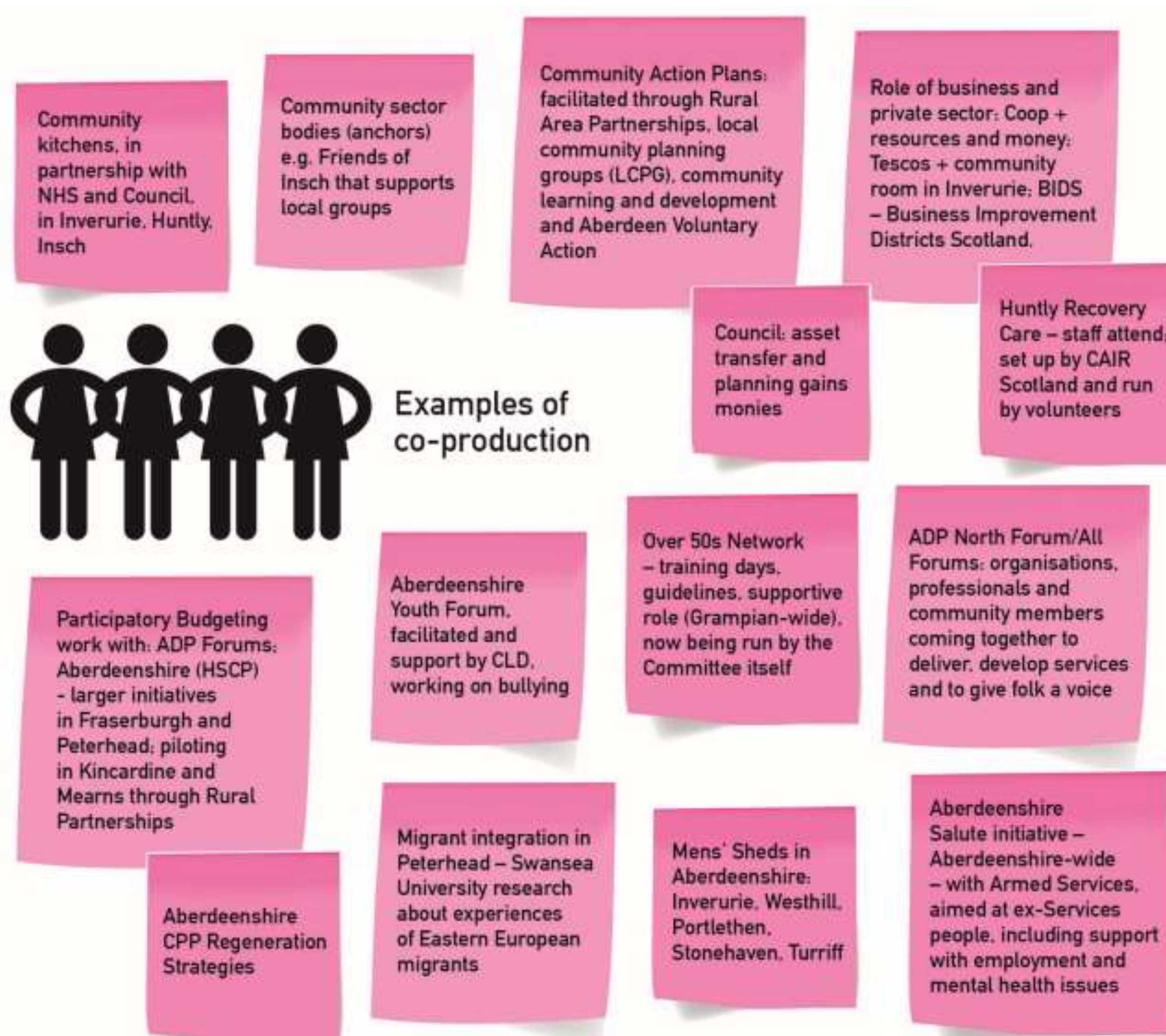
Port Soy Boat Festival – self-sustaining, and bring its money to community

Friends of Insch Hospital and ICAN, Insch Community Association

Ellan Recycling (Can Do) and Wood Recyclability

Pitscurry Project Buzzard Café

Axis Sports Centre


Community kitchens, in partnership with NHS and Council, in Inverurie, Huntly, Insch
Community sector bodies (anchors) e.g. Friends of Insch that supports local groups
Community Action Plans: facilitated through Rural Area Partnerships, local community planning groups (LCPG), community learning and development and Aberdeen Voluntary Action
Role of business and private sector: Coop + resources and money; Tescos + community room in Inverurie; BIDS – Business Improvement Districts Scotland.
Examples of co-production
Council: asset transfer and planning gains monies
Huntly Recovery Care – staff attend; set up by CAIR Scotland and run by volunteers
Participatory Budgeting work with: ADP Forums; Aberdeenshire (HSCP) - larger initiatives in Fraserburgh and Peterhead; piloting in Kincardine and Mearns through Rural Partnerships
Aberdeenshire Youth Forum, facilitated and support by CLD, working on bullying
Over 50s Network – training days, guidelines, supportive role (Grampian-wide), now being run by the Committee itself
ADP North Forum/All Forums: organisations, professionals and community members coming together to deliver, develop services and to give folk a voice
Aberdeenshire CPP Regeneration Strategies
Migrant integration in Peterhead – Swansea University research about experiences of Eastern European migrants
Mens' Sheds in Aberdeenshire: Inverurie, Westhill, Portlethen, Stonehaven, Turriff
Aberdeenshire Salute initiative – Aberdeenshire-wide – with Armed Services, aimed at ex-Services people, including support with employment and mental health issues

1.2 Shared learning: strengths, gaps, opportunities and issues

Discussions of the learning and issues arising from the mapping discussions highlighted:

Current strengths across the CPP:

- *Good links between organisations in some (local) places;* inclusive of people and partners bringing together the community sector and community planning.
- *Existing platforms for sharing knowledge* e.g. Aberdeenshire Voluntary Action, Rural Partnerships, ADP Forums and building links between sectors and partners.
- *Lots of increasingly complex local community sector activity developing*, e.g. development trusts, patient safety groups, local community provision (lunch clubs).

Gaps and concerns:

- *Complexity of good practice* – it takes time to learn how to work with communities:
    - Targeting (hard-to-reach) groups doesn't always work – need to 'go to them'.
    - Community conversations may not lead to actions – needs patience.
    - Don't have strong evidence on all local approaches – need to collect learning.
- *Needing to further build the 'community infrastructure':*
    - Communities are filling gaps as statutory services focus on complex cases.
    - Public service contracting is not necessarily aimed at smaller local bodies.
    - Sharing information: both a shortage and an overload – how to find balance?
    - Need for more volunteers – suitable funding and support for volunteer bodies
- *Dialogue, diversity and difficult conversations:*
    - Communicating with communities on health, social care and wider changes.
    - Complex change is asking challenging questions of services and communities.
    - Working with realities – not all communities are close-knit, some change fast.
- *Policy context:* the challenge as 'austerity' continues and funding gets tighter still.

Opportunities and resources:

- *Local organising and coordination:*
    - Local third sector hubs, e.g. ADP in SE Aberdeen sharing offices with other third sector organisations and partners – building local third sector capacity.
    - Community development trusts as 'community anchors' and bringing together community and public sector partners.
    - Local funding initiatives e.g. ADP Forums, local health improvement funds – how to coordinate local preventative work and simplify funding applications.
- *Opportunities to explore and further develop:*
    - The Community Empowerment Act 2015 and the roles of 'community bodies' – participation requests, asset transfer, common good funds and so on
    - Investing time in partnership-building across community/third and public sectors: e.g. learning/support plans for people being released from prison.
- *Role of crisis in creating the conditions for change* – e.g. hospital closure, flooding.

1.3 Shared learning: recognising the wider policy context and challenges

The participants also began to raise and consider the challenging policy context in which HSCPs, CPPs and all involved in public service delivery are working,and specifically in relation to prevention.

Challenging economic context: researchers on health inequalities – the Scottish Public Health Observatory and NHS Health Scotland (see 3.2, 3.5 in the research report) – continue to point towards 'whole population' and economic approaches to preventing health inequalities e.g. the role of welfare, employment. Economic change is both difficult to predict and potentially powerful e.g. the impact of oil and gas downturn on employment in Aberdeenshire. How can communities and the community sector realistically seek to impact on inequalities in such a context?

The potential of community sector infrastructure – and its risks: community approaches often tend to be low cost even if there are not huge financial savings to existing services or other financial returns. The JRF research (see Crisp et al., 2016 above) illustrates small but potentially valuable differences that community approaches and community capacity-building (CCB) can make in seeking to reduce or mitigate poverty. More generally, investing in community infrastructure e.g. community organisations, community anchors and community assets can build local resilience … but this won't be uniform: additional investment and support will be needed in some communities, often the more deprived, if inequalities aren't to increase.

Building understanding of the community sector within public services: the activities of 'community' and the community sector will be 'new' to many working in public services. The language of community capacity-building (CCB) is currently unfamiliar and there is a lot of discussion needed. There is a huge diversity of organisations, groups, activity and infrastructure – *as the mapping work above* – which the participants quickly recognised, and much for the public sector to learn in order to build towards preventative partnership working with the community sector.

This emerging body of shared learning, what's already happening in communities and the community sector and where the opportunities and challenges lie for further joint-working across partnerships and communities, is now feeding into the HSCP's developing strategic approach – see section 3 for further discussion.

2. Community Links Worker: towards a preventative approach

A cross-partnership inquiry met regularly over about 12 months to explore the learning from a Community Links Worker (CLW) pilot project in Insch, Aberdeenshire (2013-16). The CLW was supported by the Friends of Insch Hospital and Community, Aberdeenshire Voluntary Action and wider local community, third and public sector partners – see Box 1 below. The Inquiry team included the public sector – Council Improvement Officers; Policy officers from both the HSCP and CPP; Public Health; the third/community sector – a development worker and the Insch Community Links Worker; and two What Works Scotland researchers. It used this diversity to generate collaborative in-depth discussions of the evidence from desk research, a study visit and interviews, and improvement tools – see Box 2 below.

Learning from this Inquiry that supports a developing approach to preventing inequalities

As discussions deepened, themes of preventing inequalities, the preventative role of a CLW and of community capacity-building (CCB) inevitably surfaced. The Inquiry highlighted:

The CLW role – with the right wider support – as a 'promising area of practice' that can:

- support local health and wellbeing for older people: potentially increase healthy lifespan and reducing pressures on services.
- undertake anti-poverty activities: with the community sector and local community planning e.g. accessible transport; fuel poverty; advocacy for older people's issues.

However, it also raised a challenging question for further consideration in relation to preventing inequalities: might CCB increase inequalities between communities – with some communities gaining extra resources and other communities struggled to use or find them?

Consultation responses to the draft report also generated further key, related questions:

- what is the most effective targeting of resources for community capacity-building?
- how can CCB impact on HSCP spending and support a shift to preventative spend?
- what scope is there for integration of CCB and its benefits across public services?

Whilst the upstream, 'population health' approaches (see 3.1 and 3.5 in the research report) that NHS Scotland emphasise as most supportive of preventing inequalities also generate important questions about how to generate a strategic approach to CCB that will effectively support prevention.

A Research Brief for a second phase of inquiry was therefore outlined as to the potential for a CLW, and CCB more generally, to support preventative partnership working: what activities might be involved and what impacts likely; how might information and resources be shared; and what are the links to the current developments and resourcing of 'child poverty focused-action and strategies' in Aberdeenshire? – see Appendix 2(3) in the research report. Other relevant existing evidence also emerged through the research, as outlined in Box 3 (1) below.

The Community Links Worker model considered here and the collaborative inquiry approach to research and development is influencing HSCP's strategic thinking – see sections 1 and 3.

Box 1: Key learning points from the Community Links Worker inquiry and report

The post was funded by the then Aberdeenshire Community Health Partnership's use of Scottish Government's Change Fund (2013-15) and then Integrated Care Fund (2015-16). The worker engaged with people age 65 and older – and then more widely – within the catchment area for Insch Community Hospital and developed activities, groups and support within the community and supported accessing to public services.

Outputs figures for the Community Links Worker project included:

- Up to 200 older people a month engaging in community activity initiated by CLW.
- 20 people volunteering through these activities – and wider informal volunteering.
- Participants in the local activities developed reported (self-reported) widely on the value of their involvement to their physical, mental and community health.

Good practice in 'community linking' – the work of a community links worker involves:

- *Building a rich, on-going picture of each community:* via relationship-building, developing the project profile via listening/learning – don't make assumptions.
- *Linking community members into community networks:* through on-going asset mapping work and supporting peer promotion of activities
- *Developing community activities that respond to community views*: continuing discussions with communities, being realistic and learning from 'failure'.
- *Partnership working with the local community sector:* using every opportunity for learning and being very flexible and creative about community involvement.
- *Partnership working with services and wider third sector:* drawing on their knowledge, specialism and resources, and advocating on local inequality/poverty.

Supporting development of good practice in community linking requires:

- *Building from and on existing public and third/community partnership working:* collaborative work with partners provides a platform for community activity.
- *Working with one (or more) local community organisation(s):* provides local credibility, knowledge and networks; locally controlled funding 'pots' important.
- *Flexibility and openness to learning:* a worker needs to pursue this 'way of working' to build their own knowledge; partners, too, need to be open to learning.
- *Developing suitable strategies:* discussion locally and area-wide to talk through 'risk taking' and longer-term funding to support third/community sectors.
- *Make links and learning from wider regional and national experiences* about both policy and practice and the issues, challenges and opportunities that arise.

View the full Inquiry Report on the What Works Scotland website[4]

[4] http://whatworksscotland.ac.uk/publications/learning-about-community-capacity-building-from-community-links-worker-approach-aberdeenshire/

Box 2: Collaborative inquiry as ‘space’ for deepening discussions of alternatives

The Inquiry Team and researchers reflected on their learning across their work together. Discussions pointed to the value of space to read, reflect and share learning.

> *“… it makes you more confident when you go into these meetings, that you've got a bit of knowledge behind you, where things have come from, and ideas behind it.”*

> *“… it was a truly collaborative process. In other pieces of work, we speak about working collaboratively, but now I've done this what we did before wasn't that.”*

> *“… a huge luxury of the time, is to be able to do the reading. Because we see reading as a luxury, but actually it’s not, it's an essential part of our job. But we are programmed to be operational, doing the whole time …”*

The Team considered too their research process – getting a wide enough range of evidence and how best to analyse it? Is there value in external research input?

> *“ … It's part of the whole system, when you go and speak to your customer that is a very, very important voice to hear. But there are other important voices in the system that you need to hear. So, it is part of the whole. What you do is you hear what they say; you analyse what they say; and then you look for validation of what they're saying elsewhere in your system. So, it gives you that triangulation.”*

> *“… I wonder if there is a benefit of having somebody external from a university working [with us] in that research is their thing, and what that brings to a piece of work. I can't compare it, because I don't know another way, so it's difficult to say. But, at this stage, could this have been done with somebody internal?”*

The thinking also sought to imagine how the inquiry might contribute to wider preventative approaches, culture change and making ‘hard decisions’ about resource-use.

> *“Many of the activities had a focus on prevention, I think a lot of what we're doing today will have benefits in the future. So, they may start to see a reduction in treating conditions such as high blood pressure, and type two diabetes, and other conditions if people stay active and look after themselves. … I used to use those [financial costings] for volunteering, because the activities volunteers were doing – taking folk out, socialising, keeping them connected to community, visiting family – at £7.50 an hour. You were able to put a monetary value on their contribution.”*

> *“… (we) have touched six, seven, eight people, and effected some change in those people: how they think; how they work. There are 14,000 people in the Council; how many in the third sector? how many in the NHS? … Unless we think what it is we want to change in these systems, and then change the attitude of the people that work in these systems, we're on a hiding to nothing….”*

> *“…[but] for me, it is what happens now, and the influence it [the research] can have. So, in a way, it almost doesn't feel finished, for me. I would like something, you know, either for it to have influence over something still to happen, or to know that folk have given it consideration when they're looking at something new.”*

3. Learning and reflection on a developing strategic approach

Since 2015, Aberdeenshire HSCP has been on a journey of collaborative learning to build its understanding of community capacity-building (CCB) to support community health and wellbeing; and consider what makes for good practice locally and nationally. It has piloted new activities to develop its relationship with communities and supported research to deepen understanding – as illustrated in sections 1 and 2 and the evidence box 3.

In the process, the HSCP has come to understand that a simple strategic framework supporting a linear, one-size fits all approach can't do justice to the complexity of different communities and their respective capacities and needs. There is potential for on-going dialogue across a range of community planning partners including third/community sector organisations and groups to build a shared approach to community capacity building, or at least common understanding and principles – but this will likely be 'slow burner' and needing to work through local relationships and build local ownership.

There is a considerable challenge, too, to invest in the culture change – rather than tokenistic change – needed across the HSCP services and staff – and likewise other public sector bodies – so that they can recognise the potential of community sector organisations and groups and build the most productive relationships. *One key element in this process for the HSCP will be establishing a Programme Board to lead on implementation of strategic priorities for community empowerment and engagement*. It will seek to:

- share good practice, evidence and toolkits re. prevention and participation
- foster local relationships between HSCP teams and the community sector.

There are also several emerging lines of inquiry that *could* be considered through partnership and community dialogue and the work of the Programme Board(s), for example:

- The diverse roles of local partnership hubs to coordinate activity.
- 'Promising area of practice' – community links worker, community anchors and hubs
- The potential of small pots of shared local funding to support local initiatives
- Building shared dialogue re. community capacity-building tools and practices.

Integrating health and social care, the Community Empowerment (Scotland) Act 2015 and other national initiatives are creating further opportunities and challenges; for example, participatory budgeting, community links workers (social prescribing)[5], community participation requests and community asset transfer. It is crucial then to draw the depth and diversity of local knowledge and practice. Staff, managers, volunteers and activists from across services, sectors and layers offer a wealth of experience for the HSCP and CPP to draw from. There are likewise a range of flexible options, see 6.2 in the main report, to support collaborative inquiry work and which can be tested out to see what works in which context.

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[5] The Scottish Government National Programme puts emphasis on a GP-based, social prescribing model of Links Worker rather than that piloted in Insch (5.3) which pursued wider community development too.

Box 3: Evidencing on community capacity-building and prevention

(1) The diversity of community approaches and community capacity-building

What Works Scotland (draft) *Evidence Review on Community Capacity-Building for Health and Wellbeing in Rural Areas* considers relevant research, highlighting:

- The importance of local context for any CCB activity. This needs to build from the assets that a community possesses or can access. The Review identifies methods of capturing information e.g. 'asset-mapping', 'community capitals framework'.
- The importance of loca*l* social cohesion and solidarity as foundations for CCB efforts. Early CCB activity may need to support the development of cohesion and solidarity first, where this is lacking or fragile.

Community-led approaches to reducing poverty in neighbourhoods (Crisp et al., 2016): sets out four types of community-led approach – community organising; social action; community enterprise; and voluntary action – and then considers the evidence-base for the potential of each to impact on both material (income-related) and non-material (social experience) poverty. This is mixed with smaller scale initiatives lacking rigorous investigation and many approaches fitting to local conditions and opportunities.

Local research supported by the HSCP in Aberdeenshire: this includes material relating to exploring the 'Nuka' model and tools for community capacity-building, for instance: a series of research reports on the role of 'conversation cafés' illustrates how this approach can positively influence health and wellbeing, and increase community support/inclusion for people experiencing mental health problems … contact carolynlamb@nhs.net for details.

(2) Health and social care: community-based approaches and prevention

NHS Scotland's report on best preventative investment (Craig, 2014): as highlighted in 3.2 and 3.6 in the main report, argues that upstream, system-wide and whole population approaches to prevention have the strongest evidence of: reducing health inequalities; reducing costs to services; and reducing 'failure demand' – the shift to preventative approaches. The report also notes the current limits to the evidence based on community asset approaches – which creates uncertainty – and the risk of widening inequalities given the unequal distribution of assets between communities. It concludes with the need to create a more level playing across communities to support effective asset-use and help reduce inequalities.

Building Community Capacity: evidence, efficiency and cost effectiveness (Wilton, 2012) highlights evidence on the potential for community-based approaches to generate wider local economic and social benefits. Note, however, this cannot be assumed to mean that such approaches can be applicable in every context; nor, produce actual 'cashable' savings for public service budgets.

National Evaluation of Partnerships for Older People Projects (Windle et al, 2009) does provide some evidence of the potential for *cashable savings* for particular services through an extensive initiative and evaluation in England. It found that an integrated approach that brought together services and community-based activity could impact on service delivery and costs, e.g. emergency admissions, delayed discharge, duplication. There were, however, difficulties in passing savings across partners, e.g. local authorities and health services.

4. WWS commentary: the need for a deliberative approach

4.1 Developing effective multi-layered collaborative partnership working

The case study illustrates *the potential* that ongoing, multi-layered and cross-partnership inquiring and discussions can offer in seeking to build a common strategic approach across HSCPs and CPPs. Generating such a shared strategic approach to community capacity-building (CCB) is necessarily a slow-burning process and involves deepening understanding across all partners over time e.g. in understanding the complexity of issues and evidence around CCB and prevention. The suggestion here is of developing preventative partnership-working via collaborative learning, in facilitated and supportive spaces, that looks to the medium-term and shares language and knowledge to support local policy and practice. There may be quicker, shorter-term, strategic 'wins' to be had, but the potential here is to make longer-term gains through diverse knowledge and relationship-building.

4.2 Deepening understanding of 'prevention' and preventing inequalities

By drawing on a range of different evidence sources – local practices; national evidence reviews; and critical commentaries – in relation to CCB and 'prevention' – the scale of the task at hand for HSCPs and CPPs in making sense of policy and practice, and the range of options and alternatives, continues to emerge. There are growing bodies of evidence on: CCB practices – what makes them more effective and their limitations; on upstream, whole population approaches to preventing health inequalities and poverty; and on how/if prevention can reduce service demand and pressures on spending. Some of this evidence is challenging of any simple formula for *CCB as providing low cost prevention of inequalities and ill-health*; pointing to the need for good advice on evidence and understanding the wider policy context. Given complex aspirations and diverse local contexts, the resulting 'solutions' are unlikely to be precise models – rather illustrations of what can be achieved.

4.3 Seeking committed and creative approaches to preventing inequalities

Discussions in Sections 1 and 2 are illustrating the creative potential of cross-sector working. In the inquiry (Section 2), the potential of a community links worker, a strong local community organisation and a well-organised local community planning partnership comes to the fore. In the participatory workshop (Section 1), two emerging areas of practice are highlighted:

- Local hubs of various forms: third sector hubs, partnership hubs, community anchors
- Shared or pooled 'community resources' from across different budgets.

These approaches show the potential to pull together and pilot options from the wider field of community approaches (Crisp et al., 2016) including: co-production between services and community sector; community enterprise; community organising and social action; and voluntary action. There is potential here to work creatively to develop 'community infrastructure' and to engage with local communities, local politicians and 'the public' as to where to invest time, credibility and resource. This should in turn build local commitment and understanding of the policy context and opportunities for preventing inequalities.